PATIENT INTAKE PROFILE

DATE_____ NAME_____AGE_____SEX_____
NEXT PHYSICIAN VISIT_____

How did you come to know about **SOUTH TOLEDO PHYSICAL THERAPY ?**
(Please check ALL that apply)

_____ Your Doctor referred you to us.
_____ Your Case Manager referred you to us. **Name**_____
_____ A Friend or Relative referred you to us. **Name**_____
_____ Insurance Directory/ Website referred you to us.
_____ You were a previous patient here.
_____ Location/saw our sign from the road.
_____ Advertising/yellow pages/ Website **(Circle any or all)**
_____ Other

HISTORY

1) What is your chief complaint? _____
2) How did this begin? _____
3) When did this problem begin? _____
If this began more than 6 weeks ago, what prompted you to see the doctor now?
_____
4) Have you ever had a similar problem before? **YES** **NO** If yes, please explain_____
_____
5) Have you ever had any of the following conditions? **(Please circle all that apply)**
Asthma Emphysema Cancer High Blood Pressure Arthritis
Heart Problems Diabetes

SYMPTOMS INFORMATION

6) What symptoms are you having? **(Please circle all that apply)** Pain Popping Swelling Stiffness Aching Grating Cramps Catching Weakness Burning Tingling Giving out Locking Numbness Other_____

7) Is your pain? Constant_____ Intermittent_____

8) Is your pain getting (**circle one)** Better Worse No Change

9) Rate your pain **(circle one)** **0 = Best 10 = Worst** **0 1 2 3 4 5 6 7 8 9 10**

PREVIOUS TREATMENT

10) What tests have you done for this condition? **(please circle all that apply)**
X-rays EMG MRI CT Scan Myelogram Lab Tests
Other_____

11) List all surgeries.
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

12) Have you had any previous Physical Therapy? **YES or NO**
If Yes, please explain (when and for what body part(s)) _____
_____

13) Are you currently under Chiropractic care? **YES or NO**
If Yes, please explain _____

14) List current medications **(If you have a list, we can make a copy of the list)**
_____ _____ _____
_____ _____ _____
_____ _____ _____

ACTIVITY TOLERANCE

15) Because of your injury/condition, throughout the day what do you notice you:

CANNOT DO	**HAVE DIFFICULTY DOING**
_____	_____
_____	_____
_____	_____
_____	_____

16) Please list your hobbies and/ or interests_____
_____

17) List all allergies to food, medication, other substances_____
_____

18) What is your primary goal for treatment? _____
_____

Thank you. This information is very important.

_____ _____

Patient Signature **Therapist Signature**